1979

# The Medi-Cal program

William H. Tillery

# THE MEDI-CAL PROGRAM

---

A Thesis

Presented to the

Faculty of the

Public Administration Department

California State College

San Bernardino

For a

Masters of Public Administration

Degree

---

by

William H. Tillery

October, 1979

Approved by:

[redacted] April 4, 1980
Date

[redacted] March 4, 1980
JAMES J. FINLEY Date

TABLE OF CONTENTS


| CHAPTER | | Page |
|---|---|---|
| I. | INTRODUCTION. . . . . | 1 |
| | Purpose and Scope of Paper. . . . . | 1 |
| | Organization of the Study . . . . . | 3 |
| II. | BEFORE MEDI-CAL: A HISTORICAL PERSPECTIVE. . . . | 4 |
| | The County Infirmaries Act of 1860. . . . . | 6 |
| | Formation of the State Board of Health (1870) . | 7 |
| | State Grants-in-Aid . . . . . | 8 |
| | The County Government Act of 1883 . . . . . | 9 |
| | The State Department of Public Welfare (1925) . | 11 |
| | The Department of Social Wefare (1927). . . . . | 11 |
| | The Role of the Federal Government. . . . . | 13 |
| | The Social Security Amendments of 1960. . . . . | 15 |
| | The Rattigan-Burton Act . . . . . | 15 |
| | The Social Security Amendments of 1965. . . . . | 16 |
| III. | PASSAGE OF MEDI-CAL INTO LAW. . . . . | 18 |
| | The New Medi-Cal Law. . . . . | 20 |
| IV. | THE FUNCTIONING OF THE MEDI-CAL PROGRAM . . . . . | 26 |
| | County Welfare Departments. . . . . | 27 |
| | Department of Health. . . . . | 30 |
| | Medi-Cal Intermediary . . . . . | 30 |
| V. | SOME PROS AND CONS OF MEDI-CAL. . . . . | 32 |
| | Reorganization. . . . . | 32 |

Wong vs. Brian. . . . . 35
Reimbursement . . . . . 38
VI. SUMMARY AND CONCLUSIONS . . . . . 41
Recommendations . . . . . 44
GLOSSARY . . . . . 47
SELECTED BIBLIOGRAPHY. . . . . 49
APPENDIXES
1. APPLICATION FOR PUBLIC ASSISTANCE . . . . . 53
2. STATEMENT OF FACTS FOR MEDI-CAL . . . . . 55
3. MEDI-CAL RESPONSIBILITIES CHECKLIST . . . . . 61
4. RIGHTS OF PERSONS REQUESTING MEDI-CAL . . . . . 62
5. RECORD OF HEALTH CARE COSTS-SHARE OF COST . . . . 63
6. MEDI-CAL IDENTIFICATION CARD. . . . . 65
7. CONFIDENTIAL PATIENT INFORMATION. . . . . 66
8. PHYSICIAN CERTIFICATION AND JUSTIFICATION FOR EMERGENCY HOSPITALIZATION . . . . . 67
9. PRIVACY AND CONFIDENTIALITY NOTIFICATION. . . . . 68
10. MEDI-CAL NOTICE OF ACTION APPROVAL FOR BENEFITS . 69

# CHAPTER I

# INTRODUCTION

## Purpose and Scope of Paper

The Social Security Amendments of 1965[1] promised a great improvement in public medical care. Under Title XIX, the states were encouraged, through the offer of matching Federal funds, to broaden the health services offered to their medically needy.

For California in particular, the prospect of financial relief through Federal matching funds was especially significant. The California Legislature enacted implementing legislation, called the Medi-Cal Program, which took effect on March 1, 1966. Implicit in California's enabling legislation was the belief that patient composition and provision of services in county and in noncounty facilities differed from one another. It was assumed that this difference was related to the financial independence level of patients and the consequent ability of the patients to choose those providing their medical care. The Medi-Cal Program, with its primary goal of "mainstream" medical care for all, sought to reduce the alleged differences by providing the indigent with an opportunity to obtain care at a

---

[1] Social Security Amendments of 1965, Statutes at Large, XLII (1965).

medical facility of their own choice.[2]

A number of problems have developed with respect to the functioning of the Program. These include reduced and delayed recipient payments, excessive administrative paper work, long waits in line, red tape, and a host of catchy but confusing labels.[3] These and related issues need study and remediation. There is some question about the effectiveness of the Program, about whether or not it is delivering quality health care services for the needy at the least possible cost to taxpayers. A preliminary review of the literature by the author uncovered few systematic evaluations of the Program.

Accordingly, the objective of the present study was to analyze, and draw conclusions regarding the effectiveness of, the State of California's Medicaid Program known as Medi-Cal. The study was guided by the author's experience in the field. He has dealt with the system for a period of more than four years and has made numerous contacts within the county and state system. Various individuals in the Medi-Cal Program generously supplied him with information not easily or otherwise available to the public.

The chief purpose of the study was to document the extent to which the method of health care delivery itself affects its actual quality. The author anticipated that the findings of

---

[2]Margaret Greenfield, Medi-Cal: The California Medicaid Program (Title XIX) (Washington, D.C.: U.S. Department of Health, Education, and Welfare, Medical Care Administration Case Study No. 8, U.S. Government Printing Office, 1968).

[3]Ibid.

the study would be of interest to practitioners in the field of health care, the Program administrators, the California State Legislature, and recipients of Program services and benefits.

## Organization of the Study

Chapter 2 reviews the delivery of medical care in California before the advent of Medi-Cal. It includes a history of medical responsibility in California from the era of the Gold Rush days to the present.

Chapter 3 details the principal events surrounding the passage of the Medi-Cal Program. It outlines and summarizes the Medi-Cal Program which was signed into law by Governor Edmund Brown on November 12, 1965, taking effect on March 1, 1966.

Chapter 4 deals with the Medi-Cal Program itself. It reviews its provisions for medical services, eligibility requirements, and procedures for reimbursing providers.

Chapter 5 considers the pros and cons of the Program. It places special emphasis on how the Program is supposed to work as distinguished from how it is actually working. The discussion is based partly on questionnaire responses involving several actual recipient cases and on interviews with State and County Officers.

Chapter 6 provides a summary and conclusion, offering an overview and evaluation of the Medi-Cal Program.

## CHAPTER II

## BEFORE MEDI-CAL: A HISTORICAL PERSPECTIVE

Thousands of people were lured to California after 1848, drawn there by the discovery of gold at Sutter's Mill on the American River. The Forty-Niners, as these adventurers came later to be known, were unprepared for the hardships of travel and the harshness of life in mining camps or small towns. They frequently found themselves in dire need of medical care but without the required financial resources. Through certain individual voluntary actions, the medical needs of a number of those newly arrived were met.[1] However, the ever-increasing demand for medical attention soon overwhelmed the availability of local medical means.

Although the State of California considered the medical care of the poor a local responsibility at that time, it nevertheless responded to the insufficiency of suitable hospital accommodations.[2] In 1850, it authorized establishing the State Marine Hospital in San Francisco.[3] The following year, it appropriated funds for the construction of similar facilities

---

[1]Henry Harris, California's Medical Story (San Francisco: J. W. Stacey, Inc., 1932), pp. 109-112.

[2]California, Statutes (1850), chapter 30, section 11.

[3]Ibid., chapter 65, section 1.

in Sacramento and in Stockton.[4]

The response of local authorities was almost immediate. Faced with a mounting demand for services and with only limited funds available to them, the counties viewed the State-operated medical care institutions as a blessing. The counties now began transferring their poor patients to State facilities. Within a few years, the cost of care in State institutions exceeded the funds allocated to them. This imbalance resulted in a retrenchment of the provision of direct hospital services in the State.[5]

The Stockton State Hospital was reestablished as an Asylum for the Insane, while the State Marine Hospital was retrained as a center for the care of immigrants, seamen, and the indigent. The Sacramento facility was transferred to the County, to be used for the care of the poor.[6] An attempt was also made to induce local governments to assume more responsibility for the care of their indigent sick. The funds previously allocated for the maintenance of the State hospitals were divided between the State Marine Hospital and several counties.[7]

With the opening of the United States Marine Hospital in San Francisco in 1854, the one remaining State hospital facility was relieved of a major portion of its medical care obligation.

---

[4]California, Statutes (1851), chapters 127, 129.

[5]Frances Cahn and Valeska Bary, Welfare Activities of Federal, State and Local Governments in California, 1850-1934 (Berkeley: University of California Press, 1936), p. 140.

[6]California, Statutes (1853), chapters 149, 150, 179.

[7]Ibid., chapter 179.

By the end of 1855, the State had completed its abandonment of the system of general hospital care by discontinuing its San Francisco institution.[8] State-furnished hospital care for the indigent was replaced by individual county responsibility for the poor in need of health care.[9]

By 1859, only six California counties had some type of county-owned hospital facility.[10] In the remaining counties, responsibility for medical care was generally discharged by means of competitive bidding for the right to provide medical care to the indigent sick. Contracts were usually awarded to the lowest bidder, the poor often being consigned to institutions of inferior quality.[11]

## The County Infirmaries Act of 1860

Institutional care of the poor was inferior, resulting in passage of the County Infirmaries Act in 1860. Under the provisions of the Act, counties were authorized to erect separate facilities for the care of the indigent. Counties were also permitted to levy taxes for the construction and maintenance of the facilities.[12] Despite the possibility of State aid through

---

[8]California, Statutes, (1855), chapter 44, section 1.

[9]Ibid., chapter 57, sections 1-12.

[10]California State Department of Public Welfare, Biennial Report: July 1, 1924 to June 30, 1926 (Sacramento: California State Printing Office, 1927), pp. 70-71.

[11]George W. Groh, Gold Fever (New York: William Morrow, 1966), p. 186.

[12]California, Statutes (1860), chapter 247, section 1.

various tax levies, the counties continued to be reluctant to encumber themselves with the capital cost involved in housing and caring for their indigent sick. The 1860's witnessed only a modest increase in the number of county-owned facilities.[13]

## Formation of the State Board of Health (1870)

Many medical institutions were slow to respond to local needs, often showing insufficient concern for the way in which the sick were handled. This state of affairs prompted the State to take a somewhat more direct mode of action in order to correct the situation. The State Board of Health was formed in 1870.[14] It was empowered to serve as liaison between the State and other institutions in matters of construction, sanitation, and institutional administration. However, the Board lacked legal authority to compel institutions to account for the deficiencies brought to light by its inspections. The Board was forced to rely primarily on its prestige to achieve what little results it did. Its lack of effectiveness was the chief cause of its gradual decline in influence.[15]

Between 1855 and the adoption of the Constitution of 1879, the State made grants to private institutions and benevolent associations catering to the medical needs of certain segments

---

[13]California State Department of Public Welfare, Biennial Report: July 1, 1924 to June 30, 1926, pp. 70-71.

[14]California, Statutes (1869-1870), chapter 227, section 2.

[15]California State Department of Public Welfare, First Biennial Report for the Years 1870 and 1871 (Sacramento: California State Printing Office, 1871).

of the population.[16] While good intent was no doubt the motivation behind these grants, questions of propriety arose about dispensing State funds for private purposes: there were charges of favoritism. One result was that the new Constitution forbade charitable grants, although it did permit State grants-in-aid to institutions for the care of the aged poor.[17]

## State Grants-in-Aid

Taking up the option provided by the Constitution, the State began making grants in 1883 to institutions devoted to the care of the aged.[18] Early in that year, the number of county-owned hospitals stood at 28. By 1895, the year that State grants-in-aid ceased, the number of county facilities had increased by more than 50 percent.[19] With county institutions populated in large measure by the aged, the rapid expansion of facilities suggests that the grants-in-aid program was effective in bringing about improvements for that sector of the population. The expansion also indicates that, in the absence of a grant program, unassisted county hospital care of the aged and indigent sick would not have been adequate.

---

[16] Cahn and Bary, Welfare Activities of Federal, State, and Local Governments in California, p. 143.

[17] California, Constitution (1879), article 5, section 22.

[18] California, Statutes (1883), chapter 96, section 1.

[19] California State Department of Public Welfare, Biennial Report: July 1, 1924 to June 30, 1926, pp. 70-71.

## The County Government Act of 1883

During the last two decades of the nineteenth century, California's practice of providing medical care for the indigent on a lowest-bid basis became thoroughly discredited. Following public pressure, the County Government Act of 1883 prohibited the practice. Although auctioning medical care for the indigent was forbidden, those counties wishing to purchase health services for their poor on other than a bid basis were permitted to do so.[20] By 1900, 10 counties were still exercising the option of purchasing care.[21]

The turn of the century witnessed State legislation dealing with the responsibility of local government to provide the poor with medical care. Concerned over the mounting costs of that care and over the practices of certain counties encouraging their destitute to seek care in neighboring counties, the State Legislature added two provisions. First, close relatives of indigents were required to participate in their support. Second, the county in which an indigent resided before his hospitalization was charged with his care.[22]

## The State Board of Charities and Corrections (1903)

The State Board of Health had been empowered to serve as the State watchdog with respect to certain aspects of

---

[20]California, Statutes (1883), chapter 75, section 5.

[21]California State Department of Public Welfare, Biennial Report: July 1, 1924 to June 30, 1926, pp. 70-71.

[22]California, Statutes (1901), chapter 210, sections 4, 6.

institutional medical care. However, it failed to discharge its responsibility adequately. Rather than bolster the waning influence of the Board, the State created an entirely new body in 1903, invested with considerable investigatory powers. Commissioned to exercise, among other duties, supervisory responsibility for public charitable institutions, the State Board of Charities and Corrections was invested with court-enforceable legal authority.[23]

The new Board made its first report to the Governor in 1904. The Board mentioned visits it had made to the various counties for the purpose of determining the manner in which institutional care of the poor was being furnished and the condition of the facilities being used. The report noted a dual function served by county institutions: as hospitals for the acutely ill and as poorhouses for the aged and chronically disabled. The report asserted that the institutions ranged from well-equipped modern hospitals to little more than sheds offering some protection against inclement weather.[24] Under the aegis of the State Board of Charities and Corrections, slow but steady progress was made toward improving care for the indigent sick.[25]

---

[23]California, Statutes (1903), chapter 364, sections 3, 4.

[24]California State Board of Charities and Corrections, First Biennial Report: July 1, 1903 to June 30, 1904 (Sacramento: California State Printing Office, 1905), pp. 45-47, 78-97.

[25]California State Board of Charities and Corrections, Tenth Biennial Report: July 1, 1920 to June 30, 1922 (Sacramento: California State Printing Office, 1923), pp. 113-118.

## The State Department of Public Welfare (1925)

Consistent with the pattern being set in other States, the California Legislature abolished the State Board of Charities and Corrections in 1925. In its place, it established a State Department of Public Welfare. The change was one in name rather than substance. The legislative action resulted in no substantive changes in county hospital procedures for treating the aged and the indigent sick.[26]

In its first biennial accounting report, the State Department of Public Welfare detailed the results of its survey of county hospitals and of its visits to a number of institutions. Of 58 counties, two had no hospitals at all, and six had separate institutions for the acutely ill and for the chronically disabled. Each of the remainder had a single facility for both types of patients. Visits made to 49 jurisdictions with county-owned facilities disclosed that more than 15 percent of these facilities were in poor physical condition.[27]

## The Department of Social Welfare (1927)

In 1927, the State Department of Public Welfare changed its name to the Department of Social Welfare.[28] Its previous goals were continued and elaborated upon by the newly-named Department: bringing about improvements in the quality of public

---

[26]California, Statutes (1925), chapter 18, section 1.

[27]California State Department of Public Welfare, Biennial Report: July 1, 1924 to June 30, 1926, pp. 57, 70-71.

[28]California, Statutes (1927), chapter 49, section 1.

institutional medical care. The Department's Third Biennial Report (1933) documented the formulation of quality standards through its efforts by which to judge the care provided in hospitals. Applying these standards, the facilities of 20 counties were rated as exemplary while 11 county facilities were categorized as primitive in nature. Aside from the four counties contracting for the medical care of their indigents, county institutions received various ratings, evenly distributed from the lowest to the highest category.[29]

In 1945, the State once again began assuming a role in financing medical care for the poor. Between the discontinuance of State grants in 1895 and State reentry into the field in 1945, the care of the destitute sick was the sole obligation of local governments. This duty, as already mentioned, was generally discharged by providing medical services at the county hospital. For the indigent, charity at private hospitals was the only alternative to county hospital services. Private charity generally filled only a small portion of the existing need.

With the enactment of a new statute in 1945, the State began sharing the cost of the long-term care of aged public-assistance recipients in county hospitals.[30] In the same year, a revitalized State Department of Public Health received

---

[29]California Department of Social Welfare, Third Biennial Report: July 1, 1930 to June 30, 1932 (Sacramento: California State Printing Office, 1933), pp. 72-75.

[30]California, Statutes (1945), chapter 731, section 1.

legislative authority to license private hospitals.[31] To maintain standards of care in county hospitals equal to those of community hospitals, the Social Welfare Department contracted with the Department of Public Health in 1947 for the inspection of county facilities.[32] In 1949, all responsibility for the inspection and supervision of county hospital facilities was transferred to the Department of Public Health by legislative mandate.[33]

## The Role of the Federal Government

In other States, progress was also being made in the improvement of quality care of the destitute sick. However, the effort was neither uniform nor widespread. By the mid-1950's, the inadequacies of the medical attention available to the indigent and the inability or indifference of the states when it came to taking corrective measures became a Federal concern. In the Social Security Amendments of 1956, Congress authorized increased Federal matching of state and local public assistance funds for financing health services to categorical aid recipients.[34]

In the following year, the California State Legislature passed laws authorizing that State's participation in the fund-matching program. The Federal law made no stipulations concerning

---

[31] Ibid., chapter 1418, section 3.

[32] California State Department of Social Welfare, Biennial Report: July 1, 1948 to June 30, 1950 (Sacramento: California State Printing Office, 1950), p. 74.

[33] California, Statutes (1947), chapter 1686, sections 1, 4.

[34] Social Security Amendments of 1956, Statutes at Large, LXX, sections 300-314.

the type of medical care qualifying for national cost-sharing, and California chose to use its funds for the provision of outpatient services.[35]

Shortly before the State program for outpatient services went into effect, California made a detailed survey of the availability of publicly-assisted health services for the poor. The survey found that 47 of the 58 California counties furnished inpatient hospital and physician care. The remaining 11 counties purchased care from other public and from private sources.

The survey also reported on the kinds of hospital services available and on the manpower available. Those facilities without certain types of services made arrangements for their purchase from private or public sources. Some form of outpatient care was provided in all but four of the institutions. In more than half of all county hospitals, physician coverage was provided on a voluntary basis by community doctors. Nursing and other services, however, were generally furnished by full-time salaried employees.

Securing approval by the Joint Commission of Accreditation of Hospitals, a national body, is considered a good measure of the quality of the care rendered. The survey found that more than sixty (60) percent of the county hospitals with at least twenty-five (25) beds were approved by the Commission.[36]

---

[35]California, Statutes (1957), chapter 1068, secton 1.

[36]Margaret Greenfield, Medical Care for Welfare Recipients--California (Berkeley: Bureau of Public Administration, University of California, 1959), pp. 42-50, 111-127.

## The Social Security Amendments of 1960

The Eisenhower Administration proposed a grant-in-aid program to help secure physician and hospital services of higher quality for the low-income elderly. In response to the proposal, Congress passed a revised bill: the Social Security Amendments of 1960. The new law provided assistance in two ways. First, it increased Federal subvention (subsidy) of State expenditures for medical care to elderly public-assistance recipients. Second, through cost sharing, it encouraged the states to develop programs of financial aid to the aged in need of medical care.[37]

## The Rattigan-Burton Act

In 1961, the California State Legislature passed the Rattigan-Burton Act. This Act was designed to take advantage of Federal (Kerr-Mills) legislation providing for medical aid to those especially in need of it. With long-term illness of the elderly in mind, the State chose to implement the Kerr-Mills legislation by focusing on chronic inpatient hospital and nursing care. As initially provided for by the law, the State program subsidized the cost of providing long-term care after the first thirty days to elderly low-income persons. Free choice of the medical-care provider by its recipient was an additional feature of the State program.[38]

---

[37] Social Security Amendments of 1960, Statutes at Large, LXXIV, sections 601-604.

[38] California, Statutes (1961), chapter 1227, section 1.

Two years after its enactment, the Rattigan-Burton Act was amended. The amendment permitted payment for care beginning with the first day of confinement, provided that the care was furnished in a county hospital or, under certain stringent conditions, in a private hospital. The Act forbade imposing liens on property owned by persons eligible for assistance as well as imposing financial responsibility on relatives.[39] The result of the original Act, as amended, was to channel virtually all elderly indigent persons into county hospitals.

## The Social Security Amendments of 1965

The Social Security Amendments of 1965 held out the hope of very great improvements in public medical care. They set up Federally-administered insurance plans to pay for inpatient and outpatient services to the aged. In the absence of the program, the elderly would have had to continue seeking medical assistance from local governments and from private charities. Under Title XIX the states were encouraged, through Federal matching of expenditures, to broaden the health services they provided to recipients of categorical assistance and to a certain segment of their medically needy population.[40]

For California, the prospect of financial relief through increased Federal assumption of medical aid costs to the needy

---

[39] California, Statutes (1963), chapter 60, sections 4, 36.

[40] Social Security Amendments of 1965, Statutes at Large, XLII, sections 303-1401.

was a major inducement.[41] Within three months after the Federal legislation was signed into law, California adopted implementing legislation. As authored by Assemblyman Casey, the State Statute called for establishing the California Medical Assistance Program, scheduled to begin operation on March 1, 1966.[42]

---

[41]U.S. Advisory Commission on Intergovernmental Relations, Intergovernmental Problems in Medicaid (Washington, D.C.: U.S. Government Printing Office, 1969), p. 108.

[42]California, Statutes (1966), chapter 4, sections 1-14.

## CHAPTER III

## PASSAGE OF MEDI-CAL INTO LAW

In February, 1965, California Assemblyman Jack Casey introduced his Act Relating to Medical Assistance for the Aged.[1] The bill (A.B. 760) incorporated three major goals that Casey had supported during the hearings:

(1) Increasing the number of eligible medically needy aged by removing the personal property restriction.

(2) Substituting prepaid health insurance for direct governmental purchase of services.

(3) Encouraging participation by the private insurance sector.

The third goal was to be achieved in two ways. First, the 30-day or $2,000 deductible provision applying to care in private institutions was abolished. Second, physicians participating in the program were to be reimbursed at rates comparable to those of large nongovernmental purchasers of health care and of medical-care institutions charging per diem rates. Numerous changes were made to assuage special-interest groups. The County Supervisors Association of California, however, was afraid that existing provisions would increase county costs,

---

[1] California, Legislature, Assembly, An Act Relating to Medical Assistance for the Aged, Regular Session, 1965, A.B. 760.

and the bill failed to clear the State Senate.[2]

During the First Extraordinary Session of the 1965 California State Legislature, two bills virtually identical to the revised A.B. 760 were introduced, one in the Assembly, the other in the Senate.[3] Neither bill passed. This time, defeat was the result of the wait-and-see attitude taken by the Legislature pending the outcome of the Congressional vote on the proposed Social Security Amendments.[4]

In September, 1965, the State Legislature was again summoned into special session. Particularly important was State implementation of Title XIX of the recently-enacted Social Security Amendments of 1965.[5] The day after the Legislature convened, a bill closely resembling the defeated A.B. 2 was placed in the hopper by Assemblyman Casey.[6] A companion measure

---

[2]Margaret Greenfield, Medi-Cal: The California Medicaid Program (Title XIX) (Washington, D.C.: U.S. Department of Health, Education, and Welfare, Medical Care Administration Case Study No. 5, U.S. Government Printing Office, 1968.

[3]California, Legislature, Assembly, An Act Relating to Public Assistance, and Making an Appropriation, First Extraordinary Session, 1965, A.B. 2; California, Legislature, Senate, An Act Relating to Public Assistance, and Making an Appropriation, First Extraordinary Session, 1965, S.B. 2.

[4]Greenfield, Medi-Cal: The California Medicaid Program (Title XIX), No. 6.

[5]California, Governor, Proclamation, "Convening the Legislature in Second Extraordinary Session," Statutes (1966), 17 September 1965, 3.

[6]California Legislature, Assembly, An Act Relating to Public Assistance, Making of an Appropriation, and Declaring the Urgency Thereof, to Take Effect Immediately, Second Extraordinary Session, 1965, A.B. 5.

introduced in the State Senate had already died in committee.[7] The new bill, A.B. 5, underwent still further revision by committees of both houses, and faced challenges in the form of substitute measures sponsored by Assembly Speaker Jesse Unruh[8] and a group of politically conservative legislators.[9] On the third of November, the bill overcame its last legislative hurdle. Nine days later, it was signed into law by Governor Edmund G. Brown.

## The New Medi-Cal Law

Incorporated into the Welfare and Institutions Code,[10] the new law guaranteed State participation in the Federal grant-in-aid program. Under its terms, the previous State programs in Public Assistance Medical Care and Medical Assistance for the Aged were abolished, a single program of medical aid taking their place.

Except for a few provisions of the law which took effect immediately, the program of basic health care and extended care services was scheduled to begin on March 1, 1966. The

---

[7] California, Legislature, Senate, An Act Relating to Public Assistance, Making of an Appropriation, and Declaring the Urgency Thereof, to Take Effect Immediately, Second Extraordinary Session, 1965, S.B. 12.

[8] Los Angeles Times, 10 October 1965, sec. 1, p. 26.

[9] California, Legislature, Assembly, An Act Relating to Public Assistance, Making of an Appropriation, and Declaring the Urgency Thereof, to Take Effect Immediately, Second Extraordinary Session, 1965, A.B. 20.

[10] California, "Basic Health Care" and "Extended Health Services," Welfare and Institutions Code, 15 November 1965, div. 9, pt. 3, c. 7, 8.

State Legislature required that the scope and duration of the services be no less than those furnished to public assistance recipients during the period 1964-1965. Aside from the five basic services demanded by Title XIX, the State authorized the following services:

A. Medical or other remedial care recognized by State law.

B. Home health care services.

C. Private duty nursing.

D. Outpatient clinic services.

E. Dental services.

F. Physical therapy and related services.

G. Prescribed drugs, dentures, prosthetic devices, and eyeglasses.

H. Other diagnostic, screening, preventive, or rehabilitative services.

I. Inpatient hospital and skilled nursing home services for aged, tuberculosis, or mental patients.

All licensed practitioners, spiritual healers, and licensed or otherwise approved medical facilities were authorized to participate in providing these services. Reimbursement to the providers was to be based on "reasonable cost." For physician care, the reimbursement rate was to take into consideration the customary charges for similar services and the prevailing charges in the community.

Initially, eligibility was restricted to four resident population groups. The first group consisted of persons and

families who would have been eligible for Federally-aided public assistance or for Medical Assistance for the Aged as of December, 1965, had these programs still been in effect. The second group consisted of public-assistance recipients. The third and fourth groups were made up of medically needy single persons and medically needy family members, respectively. For single persons, the basis of medical indigence was financial resources at or below the Aid to the Blind maintenance level. For families, the basis was resources at or below a promulgated schedule of maintenance ranging from $187.00 per month for two persons to $457.00 for a family of seven.

Subject to the availability of funds, care was to be extended to additional nonresident population elements in the following order of priority:

A. Public-assistance recipients or other persons, and families who would have been eligible for public assistance had they met residency requirements.

B. Persons and families with financial resources comparable to public-assistance recipients.

C. Persons and families with financial resources comparable to those of Medical Assistance to the Aged recipients as of December, 1965.

D. Persons and families with financial resources comparable to those of the Aid to the Blind recipients as of December, 1965.

Administration of the State program was vested in the Health and Welfare Agency. The Legislature, however, expressed

its desire that, after December, 1966, prepaid health care or contractual arrangements with private insurance companies be employed wherever feasible in furnishing or arranging for services.

To assist the Health and Welfare Agency in the execution of its tasks, a Health Review and Program Council, consisting of 11 members appointed by the Governor, was created. The Council was entrusted with the responsibility for (a) planning comprehensive health care for all medically indigent individuals by 1975, (b) promoting efficient use of health services, (c) providing for studies of the quality of care, and (d) reviewing the need for health insurance prepayment plan grading. The Council was also established to advise the Administrator of the Health and Welfare Agency concerning (a) the scope of services, (b) the reimbursement rate for health-care purveyors, (c) the limitation of services to medically needy persons should financial constraints dictate such limitation, and (d) the rules and regulations governing private insurance carrier fiscal administration.

Moneys for the operation of the state program were to be obtained from three sources: the national government, the State, and county governments. The Federal share was that received through State participation in Title XIX. California's portion consisted of several State appropriations for medical care and savings in General Fund obligations resulting from the enactment of the Social Security Amendments of 1965.

Contributions required of the counties included a charge

of one dollar per adult recipient per calendar quarter and an amount from either of two cost-sharing options. The first option required county participation to the extent of 90 percent of the 1964-1965 uncompensated cost of health care provided to categorical aid recipients and aged persons in county medical institutions. This sum was to be increased in subsequent years by an amount proportional to the increase in county population. The option required a further contribution by the county. Ninety percent of the savings in the cost of care to aged persons entitled to Title XIX benefits, but whose care was paid for under Title XVIII, were to be returned to the State.

The alternative option required participation to the extent of 100 percent of the 1964-1965 uncompensated cost of health care provided to categorical aid recipients and all other persons. It also required a contribution from the county of all savings resulting from Federal payment under Title XVIII of the cost of care to aged persons eligible for Title XIX benefits.

The moneys collected were to be deposited in a specially earmarked Health Care Deposit Fund, from which expenditures under the program were to be made.

Other major provisions of the State Act which brought it into compliance with Federal legislation included (a) a limitation on relative responsibility, (b) prohibition of a specified duration of state residence as a basis for eligibility, (c) a prohibition against the imposition of liens on the property of recipients, and (d) the assumption of cost sharing by medically

needy aged persons eligible for Medicare benefits under Part A of Title XVIII.

The State Act included two additional stipulations. Because of their crucial importance to this study, they are quoted verbatim:

> The means employed (to provide for health care) shall be such as to allow eligible persons to secure basic health care in the same manner employed by the public generally, and without discrimination or segregation based purely on their economic disability.[11]

> . . . the board of supervisors of each county may prescribe rules which authorize the county hospital to integrate its services with those of other hospitals into a system of community service which offers free choice of hospitals to those requiring hospital care. The intent of this section is to eliminate discrimination or segregation based on economic disability so that the county hospital and other hospitals in the community share in providing services to paying patients and to those who qualify for care in public medical care programs.[12]

---

[11] Ibid., c. 7, sec. 14000(b).

[12] Ibid.

# CHAPTER IV

## THE FUNCTIONING OF THE MEDI-CAL PROGRAM

Medi-Cal, as signed into law by California Governor Edmund G. Brown, was designed to broaden the health services offered to the medically needy and the medically indigent. Implicit in California's enabling legislation was the belief that patient composition and provision of services in county and in noncounty facilities differed from one another. It was further assumed that these differences were related to the level of financial independence of the patients and the consequent ability of the patients to choose their medical care providers. The Medi-Cal Program, with its primary goal of "mainstream" medical care for all, sought to lessen the alleged distinctions by allowing the indigent and the needy an opportunity to choose their own physicians and medical facilities, provided only that the physicians and medical facilities were willing to accept Medi-Cal patients. The physicians and medical facilities had to be licensed by the State and had to contract with it as providers of the needed services in order to receive payment.

The Medi-Cal program was to be administered under the rules and regulations set forth in the California Administrative Code, Title 22. Administrative control was divided into three parts: County Welfare Departments, the Department of Health, and the Medi-Cal Intermediary.

## County Welfare Departments

The local County Welfare Office has the responsibility of determining the eligibility of each person or family without regard to age, sex, disability, race, religion, color, or national origin. The Departments have three basic classifications for Medi-Cal recipients:

a. Public Assistance. Persons 65 or older, blind, or disabled and receiving a Gold Check through the Supplemental Security Income/State Supplemental Payment Program (SSI/SSP) are entitled to receive Medi-Cal. Persons receiving Aid to Families with Dependent Children (AFDC) are entitled to receive Medi-Cal. Persons not belonging to one of these assistance groups may be able to qualify for Medi-Cal benefits, in one of the two categories designated Medically Needy and Medically Indigent. These two categories are for persons and families who cannot pay all of their medical expenses.[1]

b. Medically Needy. Persons are medically needy if they are either over 65, blind, or disabled, or satisfy the conditions required for AFDC. Medically Needy persons either have too much income or property to receive a cash grant or do not wish to receive a cash grant.

c. Medically Indigent. Persons are medically indigent if they are under 65 and are not eligible for Public Assistance or as Medically Needy persons because they do not meet the

---

[1]State of California, Medi-Cal, California's Medical Assistance Program (Sacramento: California State Printing Office, 1976), pp. 2-3.

linkage requirements. Children in foster care whose needs are met through public funds and children who qualify for aid granted in connection with the adoption of children are also in the medically indigent groups.[2]

In order to determine an individual's eligibility category, the County Welfare Department has all applicants complete the following forms:

1. Application for Public Assistance, CA-1 (8/78) (Appendix 1)
2. Statement of Facts for Medi-Cal, MC210 (7/78) (Appendix 2)
3. Medi-Cal Responsibilities Checklist, MC217 (7/78) (Appendix 3)
4. Rights of Persons Requesting Medi-Cal, MC216 (7/76) (Appendix 4)

The applicant or applicants must meet certain maintenance needs and property reserve limitations. Both of these requirements are on a sliding scale based on the number of family members. The maximum monthly maintenance need for one person is $253.00; for two persons, $387.00; for three persons, $475.00; and for four persons, $565.00. If an individual's income exceeds the maximum monthly maintenance need, then the excess is that individual's share of the cost due for medical services. The property reserve limitation is $1,500.00 for one person; $2,250.00 for two persons; $2,350.00 for three persons; and $2,450.00 for four persons. If the person or family owns more than the maximum property reserve limitations, he or it is not eligible for

---

[2]Ibid., p. 3.

Medi-Cal benefits until completing the required spenddown, or sale of property in order to fall below the maximum property reserve limitation.

If the County Welfare Department determines that the person or family is eligible for Medi-Cal, a Medi-Cal card is sent to the person or family in approximately six to eight weeks. Persons and families not eligible because of income or property reserve limitations may file a complaint or request a Fair Hearing through the State Department of Social Services at one of the following locations:

Los Angeles -- 107 South Broadway, 90012, phone (213) 620-4385

Sacramento -- 744 "P" Street, 95814, phone (916) 322-2400

San Francisco -- One Hallidie Plaza, 94102, phone (415) 557-0126

They may also mail a request for a Fair Hearing to:

Office of the Chief Referee, State Department of Social Services, 744 "P" Street, Sacramento, California 95814.

Complaints and requests for Fair Hearings must be filed within one year of the action.

Persons and families eligible for Medi-Cal but required to share its cost are first given a Record of Health Care Costs--Share of Cost MC177-S(1/78)--that must be completed and returned before they receive a Medi-Cal Card MC300B (9/76). These forms are reproduced in Appendices 5 and 6, respectively. The Medi-Cal patient may currently seek medical services from any physician or medical facility that is willing and authorized to accept Medi-Cal patients.

## Department of Health

The local branch of the Department of Health must determine the need for medical services before the persons or families receive the services they require, except in emergency cases, when the services require hospitalization or are services not normally covered by the Medi-Cal Program. To admit a non-emergency Medi-Cal patient, the physician's office must complete a Treatment Authorization Request specifying his diagnosis and the procedures he is going to perform, and requesting a specific length of stay (see Appendix 7). The request must then be forwarded to the local branch of the Department of Health. The Department either approves or disapproves the request for admission to the hospital. If the Department approves, it must also either approve or reduce the length of stay requested.

When a Medi-Cal patient is admitted to a hospital on an emergency basis, the Department of Health is not notified and the physician does not have to request authority to admit the patient to a hospital. A Physician Certification and Justification for Emergency Hospitalization form (see Appendix 8) must be completed by the physician and submitted to the Medi-Cal Intermediary by the hospital, with the claim.

## Medi-Cal Intermediary

Final settlement for acute care services furnished to Medi-Cal program beneficiaries by hospitals is based on the lesser of two amounts: (a) the reasonable cost of such services, or (b) the customary charges to the general public. The Department of Health is expected to use the Health Insurance

Regulations Manual (HIRM-1) as issued and amended by the U.S. Department of Health, Education, and Welfare for the administration of Title XVIII of the Social Security Act as amended. The manual is to be used by the Department as a guide for the computation of reasonable costs.[3]

---

[3] State of California Administrative Code, Title 22, Division III, Department of Health Care Services, p. 1300.3.

## CHAPTER V

## SOME PROS AND CONS OF MEDI-CAL

A major controversy surrounding Medi-Cal concerns who really establishes policy governing the Program. Officially, Title 22 of California's Administrative Code sets forth the rules and regulations regarding Medi-Cal, but compliance is another matter. County Welfare Offices and the Department of Health can, in effect, nullify the law through interpretations consistent with their own divergent policies. This is evident from the civil class-action suit filed against the State in Wong vs. Brian and the failure of Governor Reagan's Work-or-Else Welfare Program, both discussed later in this chapter. Obviously questionable is the right of a government department or agency to exercise discretionary powers sufficient actually to negate the wishes of a legislature. Discussed hereinafter are several examples of policy, formulated by the California Department of Health and by local County Welfare Offices, not in accordance with the governmental administrative policy at the time of implementation.

### Reorganization

The California Department of Health dates only from July, 1973. At that time, three formerly independent state departments within the Health and Welfare Agency were consolidated: the Departments of Public Health, Mental Hygiene, and Health-Care Services (Medi-Cal).

There were several proponents of this consolidation,

some belonging to the administration of Governor Reagan's predecessor, Pat Brown. The reformers favored the all-embracing Health Program approach subsequently adopted, perhaps for other reasons, by the Reagan Administration. "Creation of the new department will enable the state to do a better job in both evaluating the total health needs of our population and developing effective programs to meet them," according to a 1971 Reagan press release.[1]

The reorganization became administrative policy in 1971 under Governor Reagan, but was not implemented until July, 1973. The new "super" department, still under the Health and Welfare Agency, assumed responsibility for operating all of the State's principal health programs. Listed in descending order of expense, they were Medi-Cal; Mental and Development Disabilities (mental hygiene); and Public Health (including environmental health services, laboratory services, and preventive medicine).[2]

As described in detail earlier in this study, the Medi-Cal program was designed to put the medically needy or low-income person into the mainstream of medical care offered other persons in the State of California. It allowed the patient to choose his own physician, hospital, or other health service facility, provided that the physician, hospital, or health

---

[1]Curt Dowds, "The Ailing Department of Health," California Journal, November 1975, p. 391.

[2]Ibid.

facility was willing to accept Medi-Cal patients. It was assumed that allowing the patient this choice would improve the quality of medical care in a number of ways:

1. It would reduce the patient overload in city, county, State, and Federal facilities.

2. It would make better use of all physicians, equipment, and medical facilities within the State.

3. It would reduce patient hardships by:

   a. Reducing waiting time to receive treatment by specialized physicians and facilities.

   b. Improving the mental attitude of patients in relation to the quality of the medical care received by them.

   c. Reducing the stigma attached to receiving treatment at a city, county, State, or Federal facility.

Other purposes of the Program were to reduce the overall cost of medical services by paying both the physicians and the medical facilities on an allowable cost-only basis and by allowing medical services other than emergency services only after prior authorization if the service required hospitalization.

The Medi-Cal Program was to be administered according to the rules and regulations set forth in the California Administrative Code, Title 22. Administrative control was divided into three parts:

1. The local County Welfare Offices would determine the eligibility of each person applying for Medi-Cal.

2. The local branch of the Department of Health would determine the need for medical services prior to the patient's

receiving the services required when these services include hospitalization.

3. The assigned fiscal intermediary (Blue Cross for the San Bernardino, California area) would determine the amount of payment, the allowable charges to be assessed, and the payment time period.

The County Welfare Office determines who is eligible to receive benefits, the length of time for which the benefits are to be paid, and the liability, if any, of the patient before receiving benefits. These options alone ought to place the public on its guard. Each Welfare Department has the same rules and regulations according to which to determine the eligibility of an individual. However, the problem resides not in the rules and regulations, but in complying with them and in interpreting them. Eligibility is based on a number of factors, but the two principal factors are assets and income. The Welfare Offices have had a difficult time in deciding what is an asset and what is income, as is evident from the class-action suit Wong vs. Brian.

## Wong vs. Brian

The misinterpretation of regulations became so flagrant during the period between September, 1971 and February, 1973 that a civil class-action suit was filed against the State of California. The case of Wong vs. Brian dragged through the courts until May 1975, when a judgment was finally rendered in favor of Yuet Yee Wong, et al., Plaintiffs against Earl Brian, et al., Defendants. The major points of the judgment were these:

1. That the members of the plaintiffs' class are due reimbursement for the cost of medical care that they paid or are still owing, which costs the Medi-Cal Program would have paid had the proper regulations been in effect at the time.[3]

2. That the Department of Health inform the general public of the court decision by:

   (a) making press releases available to the general news media, including television and radio in English and non-English language.[4]

   (b) posting notices in both English and Spanish in the lobbies and waiting rooms of County Welfare Departments, Employment Development Department Offices, and major hospitals serving the poor.[5]

   (c) notifying all Medi-Cal providers of the terms of this settlement and of the claimants' rights under this settlement via the "Provider Bulletins" published regularly by the Medi-Cal Intermediary Operations.[6]

   (d) notifying all County Welfare Departments of the terms of this settlement and of the rights of claimants, and instruct the counties to aid and assist claimants in obtaining reimbursement, as appropriate.[7]

The court also ordered the Department to promulgate a special regulation, to be in effect for one year, requiring all Medi-Cal providers to cooperate with the Department in making this reimbursement to claimants.[8]

---

[3] Wong vs. Brian, Superior Court of the State of California for the County of Sacramento, No. 203363, May 1975, p. 2.

[4] Ibid.

[5] Ibid.

[6] Ibid.

[7] Ibid.

[8] Ibid., p. 3.

The Department of Helath finally got around to complying with part of the court order on December 9, 1975, informing the County Administrative Officers, County Health Departments, County Welfare Departments and County Hospital Administratiors in Medi-Cal Letter No. 21-75. This letter also stated that the period from December 15, 1975 to April 15, 1976 was the only period during which it would accept claims from persons entitled to reimbursements, although the court had ordered a one-year time period. The Medi-Cal Intermediary Operations sent notices to all providers in their Medi-Cal Bulletin dated December, 1975, informing them of the court order.

However, the author and a survey he made of other members of the American Guild of Patient Accounts Managers (AGPAM) and the Health Care Managers Association (HCMA) determined that they did not recall hearing or reading about the case or court order through the various news media. Later contact with the Department of Health was of little help, as they could not or would not give the date or dates or a copy of a complying press release. They did state that a news release of this nature would probably not be of much interest to the general news media. This in itself does not prove that such a news release was not given to the general news media nor that the news release was not actually run by a news media, it does however lead one to believe that the news release was somewhat obscure at best. If the author and other members of AGPAM and HCMA had not been employed in the medical field, it is doubtful that they would have learned anything about the case or court order.

The Department of Health did, in fact, comply with the court order in certain areas. However, the amount of time allowed

for claimants to file claims and the length of time it took the Department to inform the County facilities indicates both a lack of good faith and questionable intentions on the part of the Department. The manner in which the Department has handled the court decision leads one to believe that it is not conscientiously trying to serve the health and medical needs of all Californians by its policy setting.

The Department of Health also set its own policy in other matters, as when it disregarded Governor Reagan's Work-or-Else Welfare Program, thereby making it a voluntary instead of a mandatory program. Governor Reagan laid down a policy under which individuals on welfare must accept a job if offered one or lose their welfare benefits. The program agency refused to enforce this policy "because they would not unnecessarily create tension with the welfare recipient and they would not offend public or private user agencies by sending them someone who could not do a job."[9]

Since the Department would not enforce Governor Reagan's administrative policy, it was, in effect, making policy for the State. The issue, in addition to that of whether or not there ought to be a work-or-else policy, is who should determine policy: the government or an administrative agency of the government.

## REIMBURSEMENT

The State of California Administrative Code, Title 22, states that:

---

[9]"Work-or-Else Welfare Program Called Failure, "Sun-Telegram, April 17, 1976, p. 8.

> Final settlement for acute care services furnished to Medi-Cal program beneficiaries by hospitls shall be based on the lesser of the reasonable cost of such services or the customary charges thereof to the general public. The Department, in ascertaining wheather or not costs are reasonable, will use the "Health Insurance Regulations Manual" (HIRM-1) as issued and amended by the U.S. Department of Health Education, and Welfare for the administration of Title XVII of the Social Security Act as amended; said manual will be used by the Department as a guide for the computation of reasonable costs; provided, however, the interim payments to hospitals will be determined by the use, and adjustment to current status or previous year cost information.[10]

In October, 1975, the Medi-Cal Intermediary Operations informed all Medi-Cal providers that the Department of Health, Education, and Welfare (HEW) was studying the State's proposal to implement a plan for controlled increases in hospital reimbursements. Approval could be expected after some slight modifications. Until such time as HEW approved the State's proposal, interim reimbursements for acute care would be limited to accommodation at the levels in effect on June 30, 1975. This policy was to be effective, until further notice, for all hospital inpatient services provided after June 30, 1975 except ancillary and professional services, and would not affect final cost-audit settlements.

Accommodation rates that had been increased since July 1, 1975 were set back to the June 30, 1975 level for the purpose of interim Medi-Cal reimbursements. Claims already submitted for services provided on or after July 1, 1975, and billed

---

[10]State of California Administrative Code, Title 22 Division III, Department of Health Care Services, p. 1300.3

at a higher accommodation rate, were to be reimbursed at the June 30 level if they were processed for payment after mid-August. If these claims were processed and paid at the higher accommodation rate, they were not to be adjusted retroactively to the June 30 level.[11]

This reimbursement change for hospitals violated the California State Administrative Code and is currently being challenged in the courts by the California Hospital Association. If the Association is successful in winning a favorable decision, the collection of overdue funds due hospitals is still doubtful in view of the past performance of the Department of Health in complying with the Wong vs. Brian court order or Governor Reagan's Work-orElse Welfare Program.

---

[11] Medi-Cal Intermediary Operations, Medi-Cal Bulletin (Professional) No. 44, October 1975, p. 1

# CHAPTER VI

## SUMMARY AND CONCLUSIONS

Through special Medi-Cal laws and the Medi-Cal Program, the California State Legislature has sought to establish a medical program for the indigent and needy of its State. Formally, Title 22 of California's Administrative Code lays down the rules governing the Program. Actually, the intended goals of the Program have been subverted through the manner of its administration.

In particular, the California Department of Health has set policies which affect adversely the chief purpose of the Medi-Cal Program:

1. It has not always determined correctly who is eligible to receive benefits under the Program as shown by the court case Wong vs Brian.

2. It has not complied with recent court orders concerning determination of eligibility, or at least has done so in a very questionable manner as discussed early.

3. It has violated the reimbursement regulations currently in force as discussed earlier on pages 38 and 39.

4. It has refused to enforce certain administrative policies promulgated by the Governor of California as shown by the failure of Governor Reagan's Work-or-Else Welfare Program.

The Medi-Cal policies, outlined in Title 22 of the

State of California Administrative Code, are, in effect, serving only as vague guidelines for the Department of Health, County Welfare Offices, and the fiscal intermediaries. The provisions of the law governing the Program must be judged in terms of compliance and interpretation by the State agencies. Lack of compliance or misinterpretation nullifies the law for all practical purposes.

Regardless of what policies are laid down by the government, if the agencies or departments responsible for their administration fail to comply with or misinterpret the policies, they are not the policies of the government. Failure to comply with or to interpret correctly a policy is, in fact, equivalent to establishing a new policy.

Private institutions may be accused of not cooperating with the spirit of the Program due to the request by Hospital Officials who have asked the State of California for a Medi-Cal outpatient rate increase estimated a $250 million for the State. The "reasonable cost" determined by state auditors does not allow hospitals to seek their usual rates of profit. This discounts the fact that services by hospitals are not rendered to collect fees but that fees are collected so that services may be rendered. "California Hospital Association spokesman Charles White contended Medi-Cal now pays hospitals only 40 percent of the cost of caring for outpatients, those who are treated at a hospital and return home the same day."[1] The Sun-Telegram reported that "some hospitals are billing Medi-Cal from $250 to $1,000 a day for an

---

[1]"Hospitals Request Medi-Cal Rate Hike," TheEnterprise (Riverside, California), 20 December 1978, sec. 1, p. 3.

intensive-care bed, and there are 20,000 surplus beds in the state."[2] Facts that were omitted from the article included these:

1) The location of the surplus bed.

2) The types of surplus beds.

3) The actual "cost" of the Hospital billing the state.

4) The cost of the 20,000 surplus beds.

5) The fact that all hospital beds must be approved and licensed by the State.

The State, in short, is trying to put a ceiling on the cost of treatment for the poor which compels the medical industry to share the costs of the Medi-Cal Program. The Medi-Cal Program, with its primary goal of "mainstream" medical care for all, is--with its refusal to recognize the cost of medical care in today's economy--returning to the 1859 status of contracts being awarded to the lowest bidder, which practice resulted in the poor being consigned to institutions of inferior quality. The author is not of the opinion that, to be good, something must be expensive, but there is some truth in the saying "you get what you pay for." Behind all of the efforts to block legislation compelling the medical industry to share costs is the California Hospital Association, to name but one organization.

The vital profession of physicians and surgeons is no better. The CMA News dated March 7, 1975 reported that California physicians opposed the operation of outpatient departments or clinics by private or community hospitals, as well as

---

[2]"State Freezes Medi-Cal Pay to Hospitals," The Sun-Telegram, 16 July 1975, sec. A, p. 5.

contracts between hospitals and hospital-based physicians. The CMA, in the spirit of free enterprise, insisted that "physicians are independent contractors rather than hospital employees."[3]

Juding by the actual income eligibility rules for obtaining Medi-Cal treatment, one can easily come to the conclusion that the chief malady suffered by the eligible needy and indigent is starvation. Daniel Schorr's Don't Get Sick in America is a book title well taken. The health care industry is a $100 billion-plus business, rivaled only by the Pentagon and Oil for sheer dollar outreach. Oddly enough, while "socialism" in medicine is fought valiantly by the health industry lobby it does not decline the poverty dollar in the form of Federal and State handouts, especially if the fees are sufficiently handsome to assuage the indignity of having to rub elbows with the culturally deprived.

## RECOMMENDATIONS

As demonstrated by this thesis, there are many problems with the Medi-Cal Program. One problem is that social justice being sought for one segment of society may result in social injustice for another segment. Another problem is the mere size of the program. One (1) out of every five (5) persons (approximately four (4) million people) in California is eligible for Medi-Cal. Slowness, caused by government controls and regulations, has resulted in an undue burden to both providers and recipients of the program.

---

[3] CMA News, 7 March 1975

Although the social goals of the program are justified, it is the author's opinion that the program, as it is now administered and regulated, should be changed. The author is well aware that there are many ways to change or alter the program, however it is his opinion that his suggested changes, based on his knowledge and experience within the medical field, would greatly enhance the program. The care of the poor should be contracted out to selected hospitals, clinics, physicians, and surgeons, as in the case of the Kaiser Plan, Blue Cross Communicare, and other health-maintenance organizations. These selected facilities and physicians could secure the approval of the Joint Commission of Accreditation, or of a similar body, to ensure that the poor received quality medical care.

The contracts should be based on a standardized, reasonable cost plus a profit factor with allowances for increases or decreases keyed to fluctuations in the economy. Possibly, an incentive for quality care and cost containment could be built into the contracts. The higher the quality of care and the lower the cost, the greater would be the profit margin allowed.

Eligibility requirements and the guiding regulations should be simplified and a maximum time linit should be set for determining eligibility. The present application for Medi-Cal is lengthy and complicated and should be simplified, requesting only relevant information. These changes would help the providers, the applicants, and the Department of Welfare determine more accurately and more quickly who is eligible for Medi-Cal.

The Medi-Cal card with the POE labels should be eliminated entirely. A simpler method would be to use a system similar to

a bank credit card. When an individual requested treatment, the provider could call a central data center which would verify that such individual was eligible under the Medi-Cal program, assigning an authorization number. All persons on Medi-Cal are now listed on the state computer, so that minor changes would be necessitated in the present computer system.

## GLOSSARY

| | |
|---|---|
| AFDC - | Aid to families with dependent children |
| AGPAM - | American Guild of Patient Accounts Managers--A National Association with membership consisting mainly of Business and Financial Managers from the Health Care Industry. The purpose of the organization is to keep members up to date on changes within the Health Care Industry. |
| DH - | Department of Health |
| HCMA - | Health Care Managers Association--A state organization with membership consisting mainly of Business and Financial personnel from the Health Care Industry. The purpose is to keep members up to date on changes within the Health Care Management Field. |
| HIRM-1 - | Health Insurance Regulations Manual |
| Linkage - | Fulfillment of the Federal definition of being at least 65 years old, or blind, or disabled in the case of adults, or of being deprived of parental support or care in the case of children. One is considered "linked" to one of the specified categories if one satisfies the stipulated requirements. |
| Maintenance Need - | The amount of monthly income which the California State Legislature has determined that a person or family requires for food, clothing, housing, and other necessities. It varies with the number of family members. |
| Medi-Cal - | California's name for Medicaid, the joint Federal, State, and county program of medical assistance for needy and low-income persons of all ages. |
| Medicare - | A Federal health insurance program for persons 65 or more years of age and for certain disabled or blind persons regardless of their income. It is the same program in effect in all other states of the United States and is administered by the Social Security Administration. |

| | |
|---|---|
| MI - | Medically Indigent |
| MN - | Medically Needy |
| POE - | Proof of Eligibility |
| Property Reserve - | The net market value of the property of someone applying for Medi-Cal. |
| Share of Cost - | The amount a medically indigent or medically needy individual must pay or agree to pay each month toward the cost of health care services before being entitled to receive a Medi-Cal Card. |
| Spenddown - | The process of using one's excess property to pay one's medical bills in order to become eligible for Medi-Cal. |
| SSI - | Supplemental Security Income |
| SSP - | State Supplemental Payment |
| TAR - | Treatment Authorization Request |

## SELECTED BIBLIOGRAPHY

### BOOKS


Cahn, Frances, and Bary, Valeska. Welfare Activities of Federal, State and Local Governments in California, 1850-1934. Berkeley, Calif.: University of California Press, 1936

Greenfield, Margaret. Medical Care for Welfare Recipients- - California. Berkeley: Bureau of Public Administration, University of California, 1959

Groh, George W. Gold Fever. New York: William Morrow, 1966

Harris, Henry. California's Medical Story San Francisco: J. W. Stacey, Inc., 1932


### PUBLICATIONS OF THE GOVERNMENT - STATE OF CALIFORNIA


California. "Basic Health Care" and "Extended Health Services." Welfare and Institutions Code, 15 November 1965, div. 9, pt. 3, c. 7, 8.

_____.Constitution (1879), art. 5, sec. 22.

_____. Department of Social Welfare. Third Biennial Report: July 1, 1930 to June 30, 1932. Sacramento: California State Printing, 1933.

_____. Governor. Proclamation. "Convening the Legislature in Second Extraordinary Session." Statutes (1966)

_____. Legislature. Assembly. An Act Relating to Medical Assistance for the Aged. Regular Session, 1965, A.B. 760

_____. An Act Relating to Public Assistance, and Making an Appropriation. First Extraordinary Session, 1965, A.B. 2.

_____. An Act Relating to Public Assistance, Making of an Appropriation, and Declaring the Urgency Thereof, to Take Effect Immediately. Second Extraordinary Session, 1965, A.B. 5., A.B. 20.

_____. Senate. An Act Relating to Public Assistance, and Making of An Appropriation. First Extraordinary Session, 1965, S.B. 2.

California. Legislature. Assembly. Senate. An Act Relacting to Public Assistance, Making of An Appropriation, and Declaring the Urgency Thereof, to Take Effect Immediately. Second Extraordinary Session, 1965, S.B. 12.

_____. State Board of Charities and Corrections. First Biennial Report: July 1, 1903 to June 30, 1904. Sacramento: California State Printing Office, 1905.

_____. Tenth Biennial Report: July 1, 1920 to June 30, 1922. Sacramento: California State Printing Office, 1923

_____. Department of Public Welfare. Biennial Reports: July 1, 1924 to June 30, 1926. Sacramento: California State Printing Office, 1927

_____. First Biennial Report for the Years 1870 and 1871. Sacramento: California State Printing Office, 1871

_____. Social Welfare. Biennial Report: July 1, 1948 to June 30, 1950. Sacramento: California State Printing Office, 1950

_____. Statutes (1850), chapter 30 section 11.

_____. (1851), chapter 129, 197.

_____. (1853), chapter 149, 150, 179.

_____. (1855), chapter 44, section 1.

_____. (1860), chapter 247, section 1.

_____. (1869-1870), chapter 227, section 2.

_____. (1883), chapter 75, section 5.

_____. (1901), chapter 210, sections 4, 6.

_____. (1903), chapter 364, sections 3, 4.

_____. (1925), chapter 18, section 1.

_____. (1927), chapter 49, section 1.

_____. (1945), chapter 731, section 1.

_____. (1947), chapter 1486, sections 1, 5.

_____. (1957), chapter 1068, section 1.

California. Statutes (1961), chapter 1227, section 1.

_____. (1963), chapter 510, sections 4, 36.

_____. (1966), chapter 4, sections 1-14.

State of California. Medi-Cal, California's Medical Assistance Program. Sacramento: California State Printing Office, 1976

State of California Administrative Code, Title 22 Division III, Department of Health Care Services

Wong vs. Brian. Superior Court of the State of California for the County of Sacramento, No. 203363, May 1975, p. 2.

PUBLICATIONS OF THE U. S. GOVERNMENT

Greenfield, Margaret. Medi-Cal: The California Medicaid Program (Title XIX). Washington, D.C. :U.S. Department of Health Education and Welfare, Medical Care Administration Case Study No. 5, U.S. Government Printing Office, 1968

_____, Medi-Cal: The California Medicaid Program (Title XIX). Washington, D. C. : U.S. Department of Health, Education, and Welfare, Medical Care Administration Case Study No. 8, U. S. Government Printing Office, 1968

Social Security Amendments of 1956, Statutes at Large, LXX, sections 300-314

_____, LXXIV, sections 601-604

_____, XLII, (1965)

_____, XLII, sections 303-1401.

U.S. Advisory Commission on Intergovernmental Relations. Intergovernmental Problems in Medicaid. Washington, D.C.: U.S. Government Printing Office, 1969

PERIODICALS

CMA News, 7 March 1975

Dowds, Curt. "The Ailing Department of Health." California Journal, November 1975, pp. 391-393.

## NEWSPAPERS

"Hospitals Request Medi-Cal Rate Hike." The Enterprise (Riverside, California), 20 December 1978, section 1, p.3

"State Freezes Medi_Cal Pay to Hospitals." The Sun-Telegram, 16 July 1975, section A, p. 5.

"Work-or-Else Welfare Program Called Failure." The Sun-Telegram, April 17, 1976 p. 8

E OF CALIFORNIA – HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SER

# PLICATION FOR PUBLIC ASSISTANCE

COUNTY OF APPLICATION

AME OF APPLICANT (PERSON FOR WHOM ASSISTANCE IS REQUIRED) | MAIDEN NAME | SOCIAL SECURITY NUMBER — —

EET ADDRESS | APARTMENT NUMBER

| | COUNTY | ZIP CODE | PHONE NUMBER |
|---|---|---|---|
| | | | |

TYPE OF PUBLIC ASSISTANCE FOR WHICH YOU ARE APPLYING *(Check appropriate boxes):*

☐ Cash Grant ☐ Medi–Cal Card ☐ Food Stamps

IF YOU ARE IN AN EMERGENCY SITUATION BECAUSE YOU HAVE NO HOUSING OR UTILITIES OR ARE FACING THE IMMEDIATE LOSS OF SOME OF THESE ITEMS, CHECK THE APPROPRIATE BOX BELOW:

I do not now have: ☐ Housing ☐ Utilities

I am about to lose: ☐ Housing ☐ Utilities

IF YOU HAVE ANOTHER EMERGENCY SITUATION THAT YOU WOULD LIKE TO DISCUSS IMMEDIATELY, PLEASE CHECK THE APPROPRIATE BOX AND EXPLAIN BELOW:

☐ Not Enough Food ☐ Medical Problem ☐ Child or Spousal Abuse ☐ Other Family Emergency

LANATION:

HAVE YOU OR YOUR FAMILY RECEIVED OR APPLIED FOR PUBLIC ASSISTANCE IN THE PAST? ☐ YES ☐ NO
*(If "YES" complete the following)*

| E AND PLACE WHERE LAST RECEIVED | TYPE OF AID (AFDC, FOOD STAMPS, MEDI–CAL, ETC.) | NAME USED(IF DIFFERENT FROM ABO |
|---|---|---|
| E AND PLACE WHERE LAST APPLIED | TYPE OF AID (AFDC, FOOD STAMPS, MEDI–CAL, ETC.) | |

The law requires that information on ethnic origin and primary language be collected. However, the information will not affect your eligibility for aid. If you do not complete this section the Eligibility Worker will make this judgement.

MY ETHNIC GROUP IS *(Check one box only):*

☐ White (Not of Hispanic Origin)
☐ Hispanic
☐ Black (Not of Hispanic Origin)
☐ Asian or Pacific Islander
☐ American Indian or Alaskan Native
☐ Filipino

MY LANGUAGE IS *(Check one box only):*
*(If you can speak and understand English, check English)*

☐ English
☐ Spanish
☐ Chinese
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Filipino (Tagalog)
☐ Other (Specify):

| SIGNATURE (OR MARK) OF APPLICANT | DATE SIGNED | *If applicant or applicant's representative cannot sign, then the Signature of one witness to the mark is required below.* | |
|---|---|---|---|
| NATURE OF APPLICANT'S REPRESENTATIVE | DATE SIGNED | SIGNATURE OF WITNESS TO MARK | DATE SIGNED |

| PRESENTATIVE'S ADDRESS | REPRESENTATIVE'S PHONE | RELATION TO APPLICANT |
|---|---|---|
| | | |

PLAIN WHY THE APPLICANT CANNOT APPLY ON OWN BEHALF

***READ THE IMPORTANT INFORMATION ON THE BACK OF THIS FORM***

***COUNTY USE ONLY***

| E NAME | STATE NUMBER COUNTY | AID | SERIAL NO. | ETHNIC ORIGIN WH H B 1 2 3 A-I F 5 7 |
|---|---|---|---|---|
| ME OF COUNTY WORKER / DATE | FORMER STATE NUMBER (IF REAPPLICATION) | | | PRIMARY LANGU. SP CH J 1 2 3 F O E V 5 6 7 8 |

PLAIN DISPOSITION OF EMERGENCY SITUATION:

low is information about the Public Assistance Program(s) for which you have applied. Please read this information carefully. You ıy obtain further detailed information about these programs by reading the handbook entitled "Aid to Families with Dependent ildren in California" available through the welfare department.

## PPLICATION PROCESSING TIME

ıe county welfare department is required to either approve or deny your AFDC application within 45 days and your Food Stamps ıplication within 30 days.

## OCUMENTATION

ou must promptly provide documents (for example: birth certificates bank books, car registration, pay stubs, documents showing wnership to land, home, etc.) and/or information requested by the welfare department so they can determine your eligibility for aid. If ou don't provide the necessary documents and information your application may be delayed or denied.

## 'ORK REGISTRATION

ı order to qualify for AFDC you may be required to register for work and to be available for and seeking work. Your eligibility worker ill tell you if you must register. If you are required to do so and you refuse, you will personally be ineligible for aid. In some situations, fusal will make the whole family ineligible.

## LIGIBILITY FOR OTHER INCOME

ll AFDC applicants must apply for and accept any income which may be available to them, such as: Unemployment or Disability enefits, Veteran's benefits, Social Security benefits, etc.

## IEDICAL COVERAGE

f your AFDC application for a cash grant is approved, you will automatically be eligible for medical coverage through the "Medi-Cal" rogram. The eligibility worker will explain the Medi-Cal program to you.

## IEVIEW OF PUBLIC ASSISTANCE CASES

he State and counties periodically review cases to ensure that eligibility for Public Assistance has been determined correctly. If your case s selected for review, you will be notified and you must cooperate in this review by providing the requested information and documents.

## OCIAL SECURITY NUMBER

ou must provide your Social Security Number(s) because the furnishing of the Social Security Number is a condition of eligibility equired by Section 402(a)(25) of the Social Security Act. The number will be used in the administration of the AFDC program.

## RESOLVING DISPUTES AND COMPLAINTS

f you are dissatisfied with any action or decision that affects your application, you should try to resolve the issue with the county welfare department. If you are unable to resolve the issue, you may file a complaint or request a fair hearing through the State Department of Social Services as follows:

For any complaint that you cannot resolve with the county welfare department you may call, write, or go in person to one of the following offices:

Los Angeles — 107 South Broadway, 90012. Phone (213) 620—4385

Sacramento — 744 P Street, 95814. Phone (916)322-2400

San Francisco — One Hallidie Plaza, 94102. Phone (415)557-0126

You may also call (800) 952-5253 in Sacramento. You will not have to pay for the call if you use this number.

For a Fair Hearing mail your request to:

Office of the Chief Referee, State Department of Social Services, 744 P Street, Sacramento, CA 95814 Phone: (916) 322-2400.

You must state that you want a hearing and why you are dissatisfied. A request for a hearing must be received by the State Department of Social Services within one year of the action with which you are dissatisfied.

62955—800 750 M 11/79 — OS

# ATEMENT OF FACTS FOR MEDI-CAL

EASE USE INK

*INSTRUCTIONS:*
*Your eligibility will be decided on the information you give on this form. Be sure to read every item. If an item does not apply to you, mark it "N/A". If you need extra space for any item, use Page 9.*

Applicant's name (Print) First Middle Last

Home Address Number Street City Zip Code

Mailing address (if different from above)

ne phone Work phone Message phone Person with whom to leave message

**COUNTY USE ONLY**

Case Name

State Number

Date of app/redetermination

mo. day year

List all family members living in the home and those out of the home for whom Medi-Cal is requested.

| Name (st Middle Last) | Sex | Birthdate Month/Day/Year | Marital Status: Single | Legally Married | Div-orced | Sepa-rated | Wid-owed | Unemployed: Yes | No | Disabled or Incapacitated: Yes | No | In the Home: Yes | No | Medi-Cal Requested: Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Applicant<br>Social Security # | | Place | | Date | | Date | | | | | | | | | |
| Spouse<br>Social Security # | | Place | | Date | | Date | | | | | | | | | |

| MARRIED CHILDREN | Sex | Birthdate Month/Day/Year | In School: Yes | No | PARENTS 1) Father's Name 2) Mother's Name | Parent Deceased: Yes | No | Parent Absent: Yes | No | Child In Home: Yes | No | Medi-Ca Req. for Ch: Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| S# | | Place | | | (1)<br>(2) | | | | | | | | |
| S# | | Place | | | (1)<br>(2) | | | | | | | | |
| S# | | Place | | | (1)<br>(2) | | | | | | | | |
| S# | | Place | | | (1)<br>(2) | | | | | | | | |
| S# | | Place | | | (1)<br>(2) | | | | | | | | |
| S# | | Place | | | (1)<br>(2) | | | | | | | | |
| S# | | Place | | | (1)<br>(2) | | | | | | | | |
| S# | | Place | | | (1)<br>(2) | | | | | | | | |
| S# | | Place | | | (1)<br>(2) | | | | | | | | |

Did any family members have medical care in the past three months? Yes ☐ No ☐ If yes:

| Care Received by | Month of Care | Type of Care | Accident Suit Pending | | Medi-Cal Requested | |
|---|---|---|---|---|---|---|
| | | | Yes | No | Yes | No |
| | | | | | | |
| | | | | | | |

Complete for any family member requesting Medi-Cal not living at home.

FIRST MIDDLE LAST

ADDRESS

FIRST MIDDLE LAST

ADDRESS

Is there anyone other than those listed in 3a living in the home? Yes ☐ No ☐ If yes:

NAME(S) RELATIONSHIP

Do you receive any money from this person? Yes ☐ No ☐

If Yes: Amount received each month $ _____ For what reason? _____

1. Are all family members living in California? Yes ☐ No ☐ If No, explain: _____

2. Do you maintain a home in another State? Yes ☐ No ☐ If Yes, explain: _____

Are all family members U.S. Citizens? Yes ☐ No ☐ If no, complete the following for all family members requesting Medi-Cal who are not U.S. Citizens.

| Name | Birthplace | Alien Registration Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Has any family member received or applied for welfare payments and/or Medi-Cal from a County Welfare Department or Social Security Office? Yes ☐ No ☐ If Yes, complete the following:

Name of family member(s) who applied for or received aid: _____

Date and place of application _____

Type of Benefit _____

Currently receiving ☐ Yes ☐ No If No, date last received _____

Is any family member requesting Medi-Cal:

65 or Over? Yes ☐ No ☐ If Yes, Name _____

Blind? Yes ☐ No ☐ If Yes, Name _____

Disabled? Yes ☐ No ☐ If Yes, Name _____

How long disabled? _____

**COUNTY USE ONLY**

Retroactive Application

Retro only ☐

Retro and continuing ☐

WR-6 procedure to be completed for all non-citizens.

Date WR-6 is signed by applicant

COUNTY USE ONLY

Complete the following information about your living arrangements:

☐ Rent a room, apartment, or house

Monthly Rent $_____

☐ Pay for room and board Monthly Amount $_____

☐ Receive free room

☐ Receive free room and board

☐ Live in a board and care facility

☐ Live in a nursing home or hospital

☐ Live in and own/buying a trailer, boat or motor vehicle

Description _____

_____

Estimated value $_____ Amount owed $_____

☐ Live in and own/buying a home

Assessed value (from tax statement) $_____

Amount owed $_____ Payment $_____

Does any family member own real property not used as a home or property of which only a portion is used as a home? Yes ☐ No ☐ If yes, complete the following

Description _____

Address _____

_____

Owner: _____

Assessed value (from tax statement) $_____

Amount owed $_____ Rent collected each month $_____

Used in part as a home? Yes ☐ No ☐

Expenses on property:

| | | How often paid: | |
|---|---|---|---|
| Interest | $_____ | Yearly ☐ | Monthly ☐ |
| Taxes & Assesments | $_____ | Yearly ☐ | Monthly ☐ |
| Utilities | $_____ | Yearly ☐ | Monthly ☐ |
| Insurance | $_____ | Yearly ☐ | Monthly ☐ |
| Upkeep & Repairs | $_____ | Yearly ☐ | Monthly ☐ |

Does any family member own a motor vehicle (including cars, trucks, motorcycles, etc.)? Yes ☐ No ☐ If Yes list:

| | MAKE & MODEL | YEAR | CLASS (from registration) | AMOUNT OWED |
|---|---|---|---|---|
| A. | | | | |
| B. | | | | |
| C. | | | | |
| D. | | | | |
| E. | | | | |

Does any family member own boats, campers (do not include trucks) motor homes, or trailers which are not used as a home? Yes ☐ No ☐ If Yes, list:

| Description | Purchase Price | Estimated Value | Amount Owed | Only means of transportation | |
|---|---|---|---|---|---|
| | | | | Yes | No |
| | | $ | $ | | |
| | | $ | $ | | |
| | | $ | $ | | |

. List assets of all family members. If none, check the box marked none.

COUNTY USE ONLY

| ITEMS | None ✓ | FAMILY MEMBERS | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Applicant | Spouse | CHILDREN Name: | Name: | Name: | Name: | Name: |
| Checks or money on hand or in the house | | $ | $ | $ | $ | $ | $ | $ |
| Money in checking account | | $ | $ | $ | $ | $ | $ | $ |
| Money in savings accounts, credit unions, or trust funds | | $ | $ | $ | $ | $ | $ | $ |
| Checks or money in safe deposit box | | $ | $ | $ | $ | $ | $ | $ |
| Stock or bonds (market value) | | $ | $ | $ | $ | $ | $ | $ |
| Notes, mortgages, trust deeds, sales contracts (market value) | | $ | $ | $ | $ | $ | $ | $ |
| Other | | $ | $ | $ | $ | $ | $ | $ |

. Does any family member have life insurance? Yes ☐ No ☐ If Yes, list:

| INSURANCE COMPANY | 1. Person Insured / 2. Policy Owned By | FACE VALUE OF INSURANCE | POLICY NUMBER | DATE POLICY ISSUED | CURRENT CASH VALUE |
|---|---|---|---|---|---|
| | 1. / 2. | | | | |
| | 1. / 2. | | | | |
| | 1. / 2. | | | | |

. Does any family member own a burial reserve or trust? Yes ☐ No ☐

If Yes, Purchase price $ _____ Amount owed $ _____

$ _____ $ _____

For whom purchased _____

. Does anyone in the family own burial plots, vaults, or crypts? Yes ☐ No ☐

For use of immediate family? Yes ☐ No ☐

If for use of anyone other than a member of the immediate family, complete the following:

Description: _____ Owned by: _____

Estimated value $ _____ Amount owed: $ _____

Does any family member own items of jewelry valued at more than $100 each (other than wedding and engagement rings)? Yes ☐ No ☐ If Yes, list:

| Description | Estimated Value | Amount Owed |
|---|---|---|
| | $ | $ |
| | $ | $ |

Does any family member own business equipment, inventory, or material (Including livestock or poultry not for personal use)? Yes ☐ No ☐ If Yes, list:

| Description | Estimated Value | Amount Owed |
|---|---|---|
| | $ | $ |
| | $ | $ |
| | $ | $ |

Has any member of your family transferred, sold, or given away any property (including money) in the last two years? Yes ☐ No ☐ If Yes, list:

| Description | Value | Amount Received |
|---|---|---|
| | $ | $ |
| | $ | $ |

Is any family member employed (other than self-employed)? Yes ☐ No ☐
If Yes, list:

| Monthly Employment Information | Employed person: | Employed person: | Employed person: | Employed person: | Employed person: |
|---|---|---|---|---|---|
| Name Employer Address | | | | | |
| Hours & days worked per wk. | Hrs. Days | | | | |
| How often paid. | | | | | |
| Earnings per check before deductions | $ | $ | $ | $ | $ |
| Deductions | | | | | |
| Federal Income Tax | $ | $ | $ | $ | $ |
| State Income Tax | $ | $ | $ | $ | $ |
| Social Security | $ | $ | $ | $ | $ |
| Mandatory Retirement | $ | $ | $ | $ | $ |
| State Disability (SDI) | $ | $ | $ | $ | $ |
| Mandatory Union Dues | $ | $ | $ | $ | $ |
| Mandatory deduction for Meals | $ | $ | $ | $ | $ |
| Expenses for tools, clothing, licenses, or materials required for work | $ Expenses for: | $ Expenses for: | $ Expenses for: | $ Expenses for: | $ Expenses for: |
| Child care expenses due to employment | $ | $ | $ | $ | $ |
| Other (except transportation) | $ | $ | $ | $ | $ |

**COUNTY USE ONLY**

Heirlooms?

Disposition of proceeds:

Note: Refer to transfer of property regulations in Title 22.

Verification (list):

_____
(date)

| ansportation to work and child care | Employee: | Employee: | Employee: | Employee: | Employee: |
|---|---|---|---|---|---|
| Round trip miles | | | | | |
| Type (own car, use someone else's car, car pool, bus, etc.) | | | | | |
| Costs: Amount paid by employer | $ | $ | $ | $ | $ |
| Rider(s) contribution | $ | $ | $ | $ | $ |
| f employee uses someone else's car, give owner's name and list expenses paid for by employee (gas, oil, upkeep, etc.) | $ | $ | $ | $ | $ |

Is any family member self-employed? Yes ☐ No ☐ If Yes, complete the following:

A. Type of business _____

location _____

B. Adjusted gross income from last tax statement $ _____

C. Is the above income expected to remain approximately the same for the current calendar year?
Yes ☐ No ☐ If No, give reason:

D. If there was no tax statement or if the answer to C is No, give an estimate for the current calendar year of the average monthly:

Gross profit $ _____
Business expenses $ _____
Net income $ _____

Does any family member receive income from a source other than employment?
Yes ☐ No ☐ If Yes, complete the following:

FAMILY MEMBERS

| TYPE OF INCOME | None | Applicant | Spouse | CHILDREN Name: | Name: | Name: |
|---|---|---|---|---|---|---|
| h grant (e.g., SSI/SSP, DC, GR or GA) | | $ | $ | $ | $ | $ |
| mployment insurance | | $ | $ | $ | $ | $ |
| ability insurance | | $ | $ | $ | $ | $ |
| ker's compensation | | $ | $ | $ | $ | $ |
| eran's benefits, including Bill | | $ | $ | $ | $ | $ |
| tary allotment | | $ | $ | $ | $ | $ |
| ial Secrutiy disability etirement | | $ | $ | $ | $ | $ |
| lroad retirement | | $ | $ | $ | $ | $ |
| n-military retirement ension | | $ | $ | $ | $ | $ |
| ld support | | $ | $ | $ | $ | $ |
| mony | | $ | $ | $ | $ | $ |
| ment from roomers | | $ | $ | $ | $ | $ |
| etary gifts/contributions | | $ | $ | $ | $ | $ |
| rest income and dividends | | $ | $ | $ | $ | $ |
| er (include income tax nds, loans, etc. received month): _____ | | $ | $ | $ | $ | $ |

**COUNTY USE ONLY**

Transportation cost allowed: (show computation)

Verification:

Tax return _____ date

Business records _____ date

Net profit from self-employment:

$ _____

Verification (list)

_____ date

# MEDI-CAL RESPONSIBILITIES CHECKLIST

_____, am applying for Medi-Cal benefits from
ne RIVERSIDE County Welfare Department (on behalf of _____).
fully understand that I have to meet certain responsibilities which are listed below, in order to be eligible for
1edi-Cal.

YOU HAVE THE RESPONSIBILITY TO notify your county representative WITHIN 10 DAYS by phone, letter or in person whenever:

- income received by you or any member of your family increases, decreases, or stops. This includes Social Security payments, loans, settlements, or income from any other source.
- you plan to visit or move outside the county or State.
- a person, whether or not related to you or your family, moves in or out of your home.
- you receive, transfer, give away or sell any item of real or personal property and whenever someone gives you or a member of your family such things as a car, house, insurance payments, etc.
- you have any expenses which are paid for by someone other than yourself.
- an absent parents returns to the home, or a member of your household becomes pregnant.
- you or a member of your family becomes employed, changes employment or is no longer employed.
- you have a change in expenses related to employment or education (for example: child care, transportation, etc.)
- one of your children drops out of school or returns to school.

YOU HAVE THE RESPONSIBILITY TO apply for and provide a Social Security number for you and any member of your family who wants Medi-Cal. This is a mandatory requirement specified in C.A.C., Title 22, Section 50187. The Social Security number may be used for case identification and/or to verify income or property.

YOU HAVE THE RESPONSIBILITY TO apply for Medicare benefits if you are blind, disabled or 64 years and 9 months of age or older and eligible for these benefits.

YOU HAVE THE RESPONSIBILITY TO report to the county department any health care coverage (insurance( you carry or are entitled to use.

YOU HAVE THE RESPONSIBILITY TO report to the county department when Medi-Cal will be billed for health care services received as a result of an accident or injury caused by some other person's action or failure to act.

YOU HAVE THE RESPONSIBILITY TO cooperate with the State of California if your case is selected for review by the Quality Control review team. If you refuse to cooperate, your Medi-Cal benefits will be discontinued.

UNDERSTAND that failure to provide necessary information or deliberately giving false information, can result denial or discontinuance of Medi-Cal benefits and an investigation of my case for suspected fraud.

UNDERSTAND that if I do not report changes promptly and, because of this, I receive Medi-Cal benefits that I n not eligible for, I may be responsible to repay the Department of Health Services.

ıereby state that the above information has been reviewed by me with the county representative. I understand lly my responsibilities.

_____ _____
Applicant Date

ıave explained the responsibilities listed above to the applicant.

_____ _____
County Representative Date

C 217 (7/78)



60706-450 1,500 M IUP – OSP

# RIGHTS OF PERSONS REQUESTING MEDI-CAL

In requesting Medi-Cal benefits from the RIVERSIDE County Welfare Department you have the following rights:

**You Have The Right To** ask for an interpreter to help you in applying for Medi-Cal if you have difficulty in speaking or understanding the English language.

**You Have The Right To** be treated fairly and equally regardless of your race, color, religion, national origin, sex or political beliefs.

**You Have The Right To** apply for Medi-Cal and to be told *in writing* whether or not you qualify for any Medi-Cal program, even if the county representative tells you during this interview that it appears you are not eligible at this time.

**You Have The Right To** review manuals containing the rules and regulations of the Medi-Cal program if you want to question the basis on which your eligibility is approved or denied.

**You Have The Right To** have all information that you give to the county welfare department kept in the strictest confidence.

**You Have The Right To** be told about the Child Health Disability Prevention (CHDP) Program and to request help in receiving services under that program if you or a member of your family is under 21 years of age.

**You Have The Right To** ask for and receive information about the Family Planning Program and to be told if you are eligible for services under that program.

**You Have The Right To** speak to a social service worker about other public or private services or resources that may be available to you.

**You Have The Right To** a fair hearing if you are dissatisfied with any action taken by the county welfare department or the State Department of Health. If you wish to ask for a fair hearing, you must do so within one year of the date the notice of action was sent by the county, or the date of the action with which you are dissatisfied.

Write to: Office of the Chief Referee
Department of Benefit Payments
744 P Street
Sacramento, CA 95814

Based on your income you may be required to pay or be billed for a portion of your medical expenses before you can receive a Medi-Cal card.

I hereby state that the above information has been reviewed by me with the county representative and that I understand fully my rights to have my eligibility determined for Medi-Cal.

_____ _____
Applicant Date

I have explained the rights listed above to the applicant.

_____ _____
County Representative Date

California—Health and Welfare Agency
Program

Department of Health Services

| CO DIST | COUNTY USE |
|---|---|
| | |

## ) OF HEALTH CARE COSTS – SHARE OF COST

READ INSTRUCTIONS ON BACK BEFORE COMPLETING

| Only Medical expenses in the following month may be listed below. | Share of Cost The amount that you must pay or obligate is: | Page of |
|---|---|---|
| Mo. Yr. | $ | Retro. Elig? (Yes/No) |

ite/Zip

expenses of family members listed below may be used to meet Share of Cost

| State Number 7 Digit Serial No. | FBU | Pers. | Name — Last, First | B | A | Birthdate Mo. Day Yr. | Sex | Other Cov. Code | Social Security No. | HIC or RR No. |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

laration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare that I receive ment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cal program fo amount. I also understand and agree that I may seek payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the patien is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".

derstand that if I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or oth d party.

aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

| VIDER NAME / Provider No. | Date of Service Mo. Day Yr. | SERVICE | Proc. Code/ Presc. No. | Total Bill $ | Billed Patient $ | Billed Medi-Cal $ |
|---|---|---|---|---|---|---|
| ATIENT NAME | | | | | | |
| ROVIDER SIGNATURE (See Declaration Above) ▶ | | | | | | |
| VIDER NAME / Provider No. | | | | | | |
| ATIENT NAME | | | | | | |
| ROVIDER SIGNATURE (See Declaration Above) ▶ | | | | | | |
| VIDER NAME / Provider No. | | | | | | |
| ATIENT NAME | | | | | | |
| ROVIDER SIGNATURE (See Declaration Above) ▶ | | | | | | |
| VIDER NAME / Provider No. | | | | | | |
| ATIENT NAME | | | | | | |
| ROVIDER SIGNATURE (See Declaration Above) ▶ | | | | | | |

STATE USE ONLY

| Day | Yr. | Reviewed By: | Trans. | Replace |
|---|---|---|---|---|
| | | | | |

of
fication

I have read the instructions on the back of this form. I agree to assume full legal responsibility for the amounts listed above in the "Billed Patient" column.

X SIGNATURE OF APPLICANT DATE

77—S (1/78)

READ INSTRUCTIONS ON BACK OF THIS FORM BEFORE COMPLETING.

59992—450 1,252M QTAD

# INSTRUCTIONS FOR RECORD OF HEALTH CARE COSTS — SHARE OF COST

## structions to Patient

At the top of the other side of this form is a box labeled "Share of Cost". The amount shown in this box is your share medical expenses for the month indicated. You must pay or agree to pay this amount of your medical bills befo Medi-Cal will pay. Medical expenses for any family member shown on the other side of this form can be used to meet th share of cost.

Take this form to anyone who has given or will give you medical services (e.g., doctor, pharmacist, hospital, etc.) in th month specified. The provider will fill in the amount of the total bill and the amount you have paid or have agreed to pa you should not pay or agree to pay more than the amount shown in the "Share of Cost" box. If the total amount in th "Billed Patient" column is more than your share of cost, you will be responsible for the entire amount shown in th column.

When the total amount in the "Billed Patient" column equals exactly your share of cost, you should then sign the botto line of the form and return it to your eligibility worker. Keep the last copy for your records. If the form has bee completed correctly, you will receive your Medi-Cal card shortly.

When you receive the card, it is your responsibility to take the card to the providers who have signed the front of the for so they can then bill Medi-Cal for the part of your medical bills which you did not have to pay or agree to pay in meeti your share of cost.

If all four of the provider boxes on the front of the form have been used and you have not met your share of cost, conta your eligibility worker for issuance of an additional form.

If you have any questions about this form, call your eligibility worker.

## ıstructions to Provider

PROVIDER — To Avoid Delay in Processing the Record of Health Care Costs, Complete All Items (3) Through (12).

| Only Medical expenses in the following month may be listed below. | Share of Cost The amount that you must pay or obligate is: | Page of |
|---|---|---|
| 2 Mo. Yr. | $ 1 | Retro. Eligi (Yes/No) |

| VIDER NAME 3 | Provider No. 4 | Date of Service Mo. Day Yr. | SERVICE | Proc. Code/ Presc. No. | Total Bill $ | Billed Patient $ | Billed Medi-Ca $ |
|---|---|---|---|---|---|---|---|
| ATIENT NAME 5 | | 6 | 7 | 8 | 9 | 10 | 11 |
| ROVIDER SIGNATURE (See Declaration Above) ▶ 12 | | | | | | | |

em (1) SHARE OF COST ..... This is the amount which must be paid or obligated by the patient.

em (2) MONTH OF EXPENSE ..... This is the month for which the patient is eligible for Medi-Cal coverage.

em (3) PROVIDER NAME ..... Enter physician, facility or other provider's name.

em (4) PROVIDER NUMBER ..... Enter provider's license number/if not a California provider, enter "out-of-state".

em (5) PATIENT NAME ..... Enter name of patient to whom service has been provided.

em (6) DATE OF SERVICE ..... Enter exact date (month, day, year) each service was performed. Do not list dates such April 2 through April 10, but list each separate day, month and year on which services w provided. The service must have been performed in the month listed in Item 2. Do not any services not yet rendered. Continuous service (such as hospitalization) should be sho as month, day, year THROUGH month, day, year.

em (7) SERVICE ..... Enter specific Medi-Cal covered service rendered.

em (8) PROC. CODE/PRESC. NO ..... Enter the procedure code number or prescription number.

em (9) TOTAL BILL ..... Enter total charge for service. Do not enter in this space any amount billed to Medicare other third party payers.

em (10) BILLED PATIENT ..... Enter the amount billed to patient. If more than one provider lists services, the totals of I 10 must not exceed amount listed in Item 1.

em (11) BILLED MEDI-CAL ..... Enter the amount of charges in excess of the billed patient amount. The sum of Items 10 11 should equal Item 9.

em (12) PROVIDER SIGNATURE ..... Signature of provider or facility representative.

## APPENDIX 6

SSA#569470397
RETRO AUG 1978

N DOB 06-05-77 M

33-82-0854638-0-03**0**10007
RUBEN C SOLIZ

C/O RICHARD F SOLIZ

3056 DATE ST
RIVERSIDE CA92507

33820854638003088279M12

*RUBEN C SOLIZ
3382-0854638-003
RC878MEDIC *77M7
N

*RUBEN C SOLIZ
3382-0854638-003
RC878MEDIO *77M7
N

*RUBEN C SOLIZ
3382-0854638-003
RC878*POEO *77M7
N

*RUBEN C SOLIZ
3382-0854638-003
RC878*POEO *77M7
N

*RUBEN C SOLIZ
3382-0854638-003
RC878*POEO *77M7
N

*RUBEN C SOLIZ
3382-0854638-003
RC878*POEO *77M7
N

E OF CALIFORNIA

CONFIDENTIAL PATIENT INFORMATION

DEPARTMENT OF HEALT

# MEDI-CAL

TREATMENT AUTHORIZATION REQUEST

Verbal Control No._____

## FOR PROVIDER USE

| IE AND ADDRESS OF PATIENT | PATIENT'S IDENTIFICATION CO. | AID | CASE NO. | FBU | PERS. NO. |
|---|---|---|---|---|---|
| FIRST M.I. | NAME OF COUNTY | | | | |
| ESS | SEX | AGE | DATE OF BIRTH | | |

IE

ESS

HE ABOVE NAMED PATIENT IS IN NEED OF ADDITIONAL TREATMENT WHICH WILL EXCEED IE AMOUNT AUTHORIZED WITHOUT PRIOR APPROVAL. INITIAL DIAGNOSTIC IMPRESSIONS:

THORIZATION IS REQUESTED TO CLAIM PAYMENT FOR THE FOLLOWING COMMENDED TREATMENT:

| DESCRIPTION (BE SPECIFIC) | PROCEDURE NO. | CHARGES | AUTHORIZED YES | AUTHORIZED NO | EXPLANATION |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

SIGNATURE OF PHYSICIAN OR PROVIDER _____ DEGREE _____ DATE _____

OTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.

## FOR STATE USE

PROVIDER:

☐ REQUEST DENIED.

COMMENTS:

☐ YOU ARE AUTHORIZED TO CLAIM PAYMEN FOR TREATMENT CHECKED "YES".

AUTHORIZATION EXPIRES IN _____ DAYS.

MEDI-CAL CONSULTANT

BY _____

DATE _____

# MEDI-CAL

APPENDIX 8

## INTERMEDIARY OPERATIONS

### PHYSICIAN CERTIFICATION AND JUSTIFICATION FOR EMERGENCY HOSPITALIZATION

INSTRUCTIONS: ATTACH THIS FORM TO CLAIM WHEN BILLING FOR EMERGENCY ADMISSION BEFORE FORWARDING TO MEDI-CAL.

T'S NAME

| FIRST | INIT. | PATIENT'S MEDI-CAL I.D. NUMBER CNTY. | AID | CASE NO. | FBU | PERSON NO. |
|---|---|---|---|---|---|---|
| | | | | | | |

ED INFORMATION FOR PAYMENT: All items must be completed.

ITTING DIAGNOSIS:

F COMPLAINT:

SENT ILLNESS AND JUSTIFICATION FOR HOSPITAL ADMISSION:
vant clinical information of patient's condition including specific reasons to substantiate emergency services)

certifies that these services were required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which if not diately diagnosed and treated, would lead to disability or death.

PHYSICIAN'S SIGNATURE DATE

JE CROSS OF SOUTHERN CALIFORNIA
. Box 70000 • Van Nuys, California 91470
(213) 703-2345

BLUE CROSS OF NORTHERN CALIFORNIA
1950 Franklin Street • Oakland, California 94659
(415) 645-3000

BLUE SHIELD OF CALIFORNIA
P. O. Box 7924 • San Francisco, California 94120
(415) 445-5708

8 (7-77)

## PRIVACY AND CONFIDENTIALITY NOTIFICATION

The Welfare and Institutions Code, Sections 14011 and 14012 authorizes the county welfare departments to collect certain information from you to determine if you or the persons you represent are eligible for the Medi-Cal Program. The information you provide is confidential and may only be disclosed to certain individuals, and then only to administer the Medi-Cal Program. The information you supply on the forms you must complete relating to Medi-Cal will be used by the county welfare department to establish initial and ongoing Medi-Cal eligibility; State's Fiscal Intermediaries for claim processing; Employment Development Department for Medi-Cal card production; Federal Department of Health, Education and Welfare for audit and quality control reviews, Medicare Buy-In and Social Security Account Number verification; Federal Department of Immigration and Naturalization Service for alien status verification; county hospitals and Health Maintenance Organizations for eligibility certification.

The information required is mandatory. Failure to provide the requested information will result in the county welfare department being unable to establish your initial or ongoing eligibility for Medi-Cal benefits. You have the right to look at your information and may do so at the county welfare office during regularly scheduled office hours.

| Eligibility Worker's Name | Telephone No. | Date |
|---|---|---|



MC 218 (7/78)

62992-450 100 M – OSP

State of California—Health and Welfare Agency
Medi-Cal Program

Department of Health

(County Stamp)

Department of Public Social Services
4060 Lemon Street, Room 201
Riverside, California 92501

# MEDI-CAL
## NOTICE OF ACTION
## APPROVAL FOR BENEFITS

State No.: _____
District: _____
Approval for: _____
_____
(Names)

Your application for Medi-Cal benefits has been approved.

☐ You are entitled to receive Medi-Cal benefits beginning the first day of _____ (Month). You will receive a Medi-Cal card soon. Always present this card to your doctor or any other Medi-Cal provider when you are requesting medical services.

☐ Since your income exceeds the amount allowed for living expenses, you have a share of cost to pay or obligate toward your medical care. Your share of cost is $_____ per month beginning _____.
Your share of cost was computed as follows:

| | |
|---|---|
| [Gross income | $ _____ ] |
| Net nonexempt income | $ _____ |
| Maintenance need | $ _____ |
| Share of Cost | $ _____ |

☐ Enclosed is a RECORD OF HEALTH CARE COSTS FOR _____ (Month). Please follow the instructions on the reverse side of that form. If your medical expenses exceed your share of cost for any month, a Medi-Cal card will be issued to you after the form has been completed and approved.

☐ A Medi-Cal card showing the share of cost will be mailed to you at the long-term care facility each month. The share of cost is to be paid or obligated to the facility each month.

☐ You must bring or mail verification of the following items by _____ (Date) or eligibility for Medi-Cal benefits will be discontinued effective the last day of _____ (Month).

The regulations that require this action are California Administrative Code, Title 22, Section (s):

☐ Your application has been approved for _____ (Month) only because _____
_____

The regulations which require this action are California Administrative Code, Title 22, Section(s):

_____ (Eligibility Worker) _____ (Phone) _____ (Dated)

**PLEASE READ THE REVERSE SIDE OF THIS NOTICE**

# IMPORTANT INFORMATION

## REPORTING RESPONSIBILITY

You are responsible for notifying the county welfare department of any changes in income, property, other health care coverage, or any changes in your family's circumstances within ten days. You may be responsible to repay the Department for any overpayment of benefits due to your failure to report changes promptly. Failure to tell the county welfare department about other health care coverage or failure to use other coverage available to you is a misdemeanor.

If you have any questions about this action or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you in person.

## RIGHT TO A FAIR HEARING

If you are dissatisfied with this action, you may request a conference with representatives of the county welfare department. You also have the right to a fair hearing if you are dissatisfied with any action taken by the county welfare department regarding your eligibility, or any action taken by the Department of Health regarding the benefits you are entitled to receive.

Should you request a conference, you or your authorized representative will be given an opportunity to discuss your situation, obtain an explanation of reasons for the action being taken, and present information on your behalf. The opportunity for a conference does not change your right to a fair hearing. If you want a conference, you must contact the county welfare department within ten days of the date this notice was mailed.

If you request a fair hearing, you will be given adequate notice of the time, date, and place. Fair hearings are conducted by impartial referees and hearing officers, and you will have the opportunity in advance to examine all documents and records to be used at the hearing, and may represent yourself or be represented by legal counsel, by a friend, or others. The county welfare department can advise you of free legal services which may be available in your community. You or your representative may bring witnesses, establish pertinent facts, make arguments, cross-examine witnesses, and refute testimony or evidence. Following the hearing, the Department of Health will issue its written decision. A request for a fair hearing must be made in writing. You must state that you want a hearing and tell why you are dissatisfied. A request for a hearing should be sent to one of the following addresses:

Office of the Chief Referee
State Department of Benefit Payments
744 P Street
Sacramento, California 95814
Telephone: 916/445-8525

Los Angeles County Residents send to:
Fair Hearing Section
P.O. Box 10280
Glendale, California 91209

A request for a fair hearing must be received within one year of the date of this action. If a fair hearing is requested within ten days of the mailing date of this notice, and if the State determines that the issues concern facts or judgment relating to your individual case, rather than State policy, the action will not be effective until the fair hearing decision is rendered.

State regulations governing fair hearings are available at the county welfare department. Your county worker will assist you, if you wish, in preparing and submitting your request for a fair hearing.